



Stonington
Institute

Client Name: _____

DOB: _____

Place Client Record Label here

Release of Information Authorization

This form must be filled out completely to be valid

I, _____, hereby authorize Stonington Institute to
☐ disclose information regarding myself to AND/OR ☐ obtain information regarding myself from

Name: _____

Address: _____

Phone: _____ **Fax:** _____

Purpose: ☐ Aftercare ☐ Personal ☐ Legal ☐ Other: _____

How Information is to be Released:

_____ Written Release _____ Verbal Release _____ Electronic Release

Type of Information to be Released: (check all that apply)

_____ Discharge Summary _____ Dates of Admission/ Discharge

_____ Bio-Psychosocial Assessment _____ Diagnosis

_____ Letter of Verification of Treatment _____ Progress in Treatment

_____ Labs/PPD _____ Mental Status Examination

_____ Psychiatric Evaluation _____ Psychological Evaluation _____

Other: (Specify) _____

- This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, **this consent will expire one year from date** of signature unless otherwise specified. _____

The confidentiality of this record is required under Chapter 899 P.L. 93-579 of the Connecticut General Statutes as well as Title 42 of the United States Code. This material should not be transmitted to anyone without the client's written consent or authorization as provided for in these Statutes.

- I understand that the medical record to be released may contain information pertaining to psychiatric, drug, and/or alcohol abuse diagnosis and treatment, and may also contain confidential HIV (AIDS) related information. A general authorization for the release of medical or other information is NOT sufficient for this purpose.
- I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the client and thus may no longer be protected by federal privacy regulations.
- I understand that I may inspect or copy the information to be used or disclosed.
- I understand that my current treatment or continued treatment by Stonington Institute is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it.

Client/Guardian Signature: _____ **Date:** _____

Client Date of Birth: _____ **Client SS#:** _____

Witness Signature: (if required) _____

Mail or Fax to:

☐ 75 Swantown Hill Road, North Stonington, CT 06359

Fax: 860-535-9076

☐ 428 Long Hill Road, Groton, CT 06340

Fax: 860-449-1332

☐ 1353 Gold Star Highway, Groton, CT 06340

Fax: 860-448-7394

Questions? Please call 860-445-3000 and ask for the Health Information Department.